

**EMPLOYER RESPONSE—MEDICAL SEPARATION**

Date: \_\_\_\_\_

NOTE: THIS INFORMATION WILL BE USED TO DETERMINE CLAIMANT'S  
ELIGIBILITY AND MAY ALSO AFFECT YOUR CHARGEABILITY RATE.

Claimant Name:	SSN:
SALMON LOCAL OFFICE IDAHO DEPT OF COMMERCE AND LABOR PO BOX 990 SALMON ID 83467-0990  208-756-4672 (FAX)	Employer's Name, Address, Phone & Fax

**Paid or to be paid:**

Gross earnings for the past 12 months \$	Severance: \$	On (date):
Vacation: \$	Bonus: \$	On (date):
Date payment will be received:	Holiday: \$	On (date):
Rate of Pay per hour: \$	Pension or Retirement pay was paid or will be paid:	
	\$	On (date):
Supervisor's Name:	Employer's Phone#:	
Start Date of Employment:	Last Day worked:	
Date of Separation:		

Do you have a leave policy for employees who are unable to work? Yes ☐ (Please provide copy) No ☐Did the claimant discuss the possibility of a leave with you? Yes ☐ No ☐

Briefly explain your leave policy.

Are you holding the claimant's job for him/her? Yes ☐ No ☐

If the claimant is on a leave beginning date \_\_\_\_\_ ending date \_\_\_\_\_

Did claimant discuss the possibility of other work with you? Yes ☐ No ☐Do you have other work, which would accommodate the claimant's limitations? Yes ☐ No ☐

Position: \_\_\_\_\_ Hours per day: \_\_\_\_\_ Rate of Pay: \_\_\_\_\_

If yes, did you offer this work to the claimant? Yes ☐ No ☐ If not, why not? \_\_\_\_\_Did the claimant provide you with verifiable information (Medical statement—visual observation) of his/her ability to work? Yes ☐ No ☐ Explain: \_\_\_\_\_

Please provide any additional information you believe should be considered in determining claimant's eligibility.

*NOTE: PLEASE ATTACH ANY RELATED DOCUMENTATION TO SUPPORT YOUR POSITION*

For example written warnings, policy manuals, time cards, personnel records, statements from first-hand witnesses, written customer complaints, police reports, and other evidence to support your statement(s)

Employer/Employer's Representative Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_